

# Navajo Nation Employee Benefit Plan

Coverage Period: 01/01/2014-12/31/2014 (Edited 12/2013)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Employees & Dependents | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.hmatpa.com](http://www.hmatpa.com) and [www.isd.benefits.navajo-nsn.gov](http://www.isd.benefits.navajo-nsn.gov) or by calling 1-800-448-3585 or (928) 871-6300.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	<b>Medical: \$250</b> individual/ <b>\$500</b> family; per calendar year.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your plan document to see when the <b>deductible</b> starts over. See the chart starting on pg. 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	<b>Dental: \$100</b> individual/ <b>\$300</b> family; per calendar year. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. <b>Medical: \$2,750</b> individual/ <b>\$5,500</b> family; per calendar year.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, co-payments; charges in excess of the usual, customary and reasonable allowances; charges in excess of the maximum benefits payable under this Plan; charges covered under the dental or vision care program of this Plan; penalties assessed for non-compliance with the pre-certification process; charges for health care services not covered by this Plan.	Although you pay these expenses, they do not count toward the out-of-pocket limit. Refer to pg. 45 of the Plan Document.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on pg. 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network</b> of <b>providers</b> ?	Yes. See <b>Primary:</b> <a href="http://www.hmatpa.com">www.hmatpa.com</a> or <b>Secondary:</b> <a href="http://www.multiplan.com">www.multiplan.com</a> for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. See the chart starting on pg. 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without permission from this plan
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on pg. 5. See your policy or plan document for additional information about <b>excluded services</b> .

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network or participating **providers** by charging you lower, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals.
	Specialist visit	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
	Other practitioner office visit (Alternative Care- Chiropractic)	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	Maximum benefit \$1000.00 per person; per calendar year
	Preventive care/screening /immunization	No Charge	May be balance billed	Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
If you have a test	Diagnostic test (x-ray, blood work)	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
	Imaging (CT/PET scans, MRIs)	20% after annual deductible has been met Pre-Cert is required	20% after annual deductible has been met / plus balance billing Pre-Cert is required	
If you need drugs to treat your illness or condition. More info about prescription drug coverage is available at www.mycatamaranrx.com.	Generic drugs	\$10 / prescription	\$10 / prescription	Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals. Must use Brivoa Specialty pharmacy only for specialty drugs.
	Preferred brand drugs	\$20 / prescription	\$20 / prescription	
	Non-preferred brand drugs	\$35 / prescription	\$35 / prescription	
	Specialty Drugs (Self-Injectables)	20% with max copay of \$150	Not covered	
	Mail order benefit is also available; \$10 co-pay for a 90-day supply			

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
	Physician/surgeon fees	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
If you need immediate medical attention	Emergency room services	20% after \$250 co-pay/visit and annual deductible has been met	20% after \$250 co-pay/visit and annual deductible has been met / plus balance billing	Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
	Emergency medical transportation	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
	Urgent care	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after \$250 co-pay/stay and annual deductible has been met	20% after \$250 co-pay/stay and annual deductible has been met / plus balance billing	All Inpatient stays require Pre-Cert Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
	Physician/surgeon fee	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	All Inpatient stays require Pre-Cert Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
	Mental/Behavioral health inpatient services	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
	Substance use disorder outpatient services	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
	Substance use disorder inpatient services	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
If you are pregnant	Prenatal and postnatal care	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	All Inpatient stays require Pre-Cert Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
	Delivery and all inpatient services	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Home health care	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	<b>This category of services requires Pre-Cert.</b> Home Health limited to 400 hours per member/per calendar year Skilled Nursing- limited to 60 days per calendar year Excludes expenses to which a covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
	Rehabilitation services	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
	Habilitation services	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
	Skilled nursing care	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
	Durable medical equipment	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
	Hospice service	20% after annual deductible has been met	20% after annual deductible has been met / plus balance billing	
If you or your child needs dental or eye care	Eye exam	Amount that exceeds the annual limit \$200	Amount that exceeds the annual limit \$200 / plus balance billing	Frame benefit is limited to every 24 months.  Excludes expenses to which the covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals
	Glasses/Contact Lens	Amount that exceeds the annual limit \$200	Amount that exceeds the annual limit \$200 / plus balance billing	
	Dental check-up	<u>Preventive</u> – No Charge  <u>Basic &amp; Major</u> – 20% after annual deductible has been met  <u>Orthodontic</u> - 50% after annual deductible has been met	<u>Preventive</u> - May be balance billed  <u>Basic &amp; Major</u> – 20% after annual deductible has been met /plus balance billing  <u>Orthodontic</u> – 50% after annual deductible has been met/ plus balance billing	Routine dental exams 2 per calendar year. Maximum benefit of \$2000 per person; per calendar year. Lifetime maximum benefit of \$2000 for orthodontic services per person.  Excludes expenses to which the covered member is entitled to receive from or through the United Public Health Service or any federally funded health care providers, including referrals

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Cosmetic Surgery
- Indian Health Services, Contract Health Service Referrals or Other Federally Funded Health Care Providers
- Non-Emergent Care when Outside the USA
- Occupational Illness or Injury
- Private Duty Nursing
- Self Inflicted injury
- Services that do not qualify as Medically Necessary
- TMJ Treatment
- Weight Control /Bariatric Surgery

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Alternative Care (massage therapy, chiropractic, acupuncture, hypnotherapy, holistic and naturopathic, medicines and treatment)
- Hearing Loss Benefit
- Infertility/Sterility
- Native Traditional Healing Reimbursement Benefit
- Second Opinion
- Transplants

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact HMA, LLC at 1-800-448-3585. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' (800) 448-3585

To obtain assistance in reading and understanding this document, or to receive a copy of this document written in Navajo please contact the Claim Administrator at (800) 448-3585.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Navajo Nation Employee Benefits Program at (928) 871-6300 or HMA, LLC Grievances and Appeals Department at 1-800-448-3585. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## Coverage Examples

### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

#### Having a baby (normal delivery)

- Amount owed to PPO providers: \$7,540
- Plan pays \$5,832
- Patient pays \$1,708

##### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

##### Patient pays:

Deductibles	\$250
Co-pays	\$0
Co-insurance (20% up to max OOP)	\$1,458
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,708</b>

#### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to PPO providers: \$4,100
- Plan pays \$3,080
- Patient pays \$1,020

##### Sample care costs:

Prescriptions	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
<b>Total</b>	<b>\$4,100</b>

##### Patient pays:

Deductibles	\$250
Co-pays	\$0
Co-insurance (20% up to max OOP)	\$770
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,020</b>

## Coverage Examples

### Questions and answers about the Coverage Examples:

#### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

#### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

#### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

#### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

#### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

#### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.